Please Check One

Place Photo

_____ Initial Application

Here

_____ Appeal

Passport Size

NEVADA STATE BOARD OF EXAMINERS
FOR
LONG TERM CARE ADMINISTRATORS
3157 N. Rainbow Blvd., #313
Las Vegas, Nevada 89108
Phone: (702) 486-5445
Fax : (702) 486-5439

APPLICATION FOR LICENSURE

RESIDENTIAL/NURSING FACILITY ADMINISTRATOR

(Effective Immediately <u>Only Printed or Typed</u> Applications will be accepted. Hand written applications will be rejected)

I. APPLICANT IDENTIFYING INFORMATION

PLEASE CHECK ONE:
RESIDENTIAL FACILITY ADMINISTRATOR _____ NURSING FACILITY ADMINISTRATOR _____

1. Name _____
   Last/Family First/Given Middle Maiden

2. Other Names Used _____ Mother's Maiden Name_____
   Last First

3. Social Security Number _____ 4. Telephone No. Home _____

5. Telephone No. Business_____ 6. Cell Phone: _____

7. E-mail:_____

8. Address _____
   Number/Street Apartment # City State Zip

9. Date of Birth _____ 9. Place of Birth _____ 10. United States Citizen? Yes____ No ____

II. RECORD OF LICENSURE INFORMATION

Licenses/Certificates: List all licenses, registrations or certifications issued by any state, province or country you now hold, in any other capacity, in any jurisdiction (Example: RN, LPN, etc.)?

	RFA/NFA/ RN/ CNA	State	License/Certificate Number	Active/ Inactive Disciplined	By Exam or Endorsement	Expiration Date
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____

Revised 11/10/2009

4. Have you failed a Residential/Nursing Facility Administrator's Exam in any other state? Yes _____ No _____

If yes, how many times? _____ In what state? _____

5. Do you have difficulty reading or writing English without assistance? Yes _____ No _____

Applicant's Signature _____

III. EDUCATION INFORMATION:

Please complete the form below regarding your education.

University/College/ High School/Other	Location	Month & Year Attended	Degree Diploma/Other

Note: An official copy of your grade transcripts and/or degree /diploma must be provided by the granting institution.

ONLY NURSING FACILITY ADMINISTRATOR APPLICANTS MUST COMPLETE THE FOLLOWING QUESTION:

1. Have you completed at least 1,000 hours in a program for training administrators and/or an internship or residency in a facility providing long-term care approved by a **Board of Licensure for Nursing Facilities Administrators?** _____Yes _____ No

If YES, provide the name and address of the program, a description of the course outline and a copy of transcripts or certificate received.

Applicant's Signature _____

IV. PERSONAL HISTORY INFORMATION
(All Applicants)

In order to protect the public and comply with the American Disabilities Act, please answer the following questions. If the response is yes, carefully read the information after each question and provide all necessary documentation. Your application will not be considered complete without it.

1. Has your license, registration or certification in any state ever been denied, revoked, suspended, reprimanded, fined, surrendered, restricted, limited or placed on probation? Yes _____ No _____

If the answer is yes, you must submit the following:

_____ a detailed letter of explanation of the action, state where the action took place and the circumstances leading to the action.
_____ copies of records and orders from the agency that took the action identifying the allegations, action taken and current action status.

2. **HAVE YOU <u>EVER</u>, SINCE ATTAINING THE AGE OF 18 YEARS, BEEN CHARGED, EVEN IF CHARGES WERE DROPPED, OR DISMISSED, OR CONVICTED OF A CRIMINAL OFFENSE WHETHER A FELONY, GROSS MISDEMEANOR OR MISDEMEANOR, PLACED ON PROBATION, OR GRANTED DEFERRED ADJUDICATION, PRETRIAL DIVERSION OR HAD RECORDS SEALED OR EXPUNGED, OR ADVISED BY AN ATTORNEY THAT YOU DO NOT HAVE TO LIST THE CONVICTION, IN ANY JURISDICTION?**

IF YOU HAVE ANY QUESTIONS AS TO HOW TO RESPOND TO THIS QUESTION, PLEASE CALL THE BOARD OFFICE AT (702) 486-5445 FOR CLARIFICATION.

Yes _____ No_____

<u>PLEASE NOTE:</u> <u>FAILURE TO FULLY AND COMPLETELY DISCLOSE ANY FORMER CHARGES, ARRESTS OR CONVICTIONS MAY RESULT IN DENIAL OF YOUR LICENSE.</u>

If the answer is yes, you must submit the following:

_____ a detailed letter of explanation including date of offense, circumstances leading to arrest, conviction, sentence, additional convictions and current status of sentence.

_____ copies of court documents identifying actual conviction and sentence.

_____ a letter from parole/probation officer regarding compliance with requirements or copy of document identifying completion of sentence.

_____ a criminal history printout from a FBI fingerprint check.

3. Within the past five years have you been diagnosed, treated or hospitalized for a psychiatric or mental health condition that could/may result in your not being able to practice the essential job functions of a Residential/Nursing Facility Administrator?

Yes _____ No _____

If the answer is yes you must submit the following:

_____ a detailed letter of explanation including diagnosis, past treatment efforts (inpatient or out patient), date of last treatment and current treatment plan.

_____ documentation from treating practitioners regarding diagnosis (Axis I - V), medications, treatment modality, treatment plan, current mental status and statement regarding ability to function, cope with a stressful situation or reason and make sound judgments.

4. Within the past five years have you been diagnosed as having a physical or medical condition which will result in your not being able to practice the essential job function of a Residential/Nursing Facility Administrator?

Yes _____ No _____

If the answer is yes you must submit the following:

_____ A detailed letter of explanation of the condition and how it may interfere with your ability to practice.

_____ A letter from your treating practitioner regarding diagnosis, extent of the condition and your ability to practice.

"A "YES ANSWER" TO ANY OF THE ABOVE QUESTIONS WILL AFFECT THE PROCESSING OF YOUR APPLICATION AND MAY RESULT IN ISSUING AN UNRESTRICTED, LIMITED OR RESTRICTED LICENSE. FAILURE TO ANSWER TRUTHFULLY IS GROUNDS FOR A FRAUDULENT APPLICATION AND MAY RESULT IN DISCIPLINARY ACTION.

Applicant's Signature _____

V. CHILD SUPPORT INFORMATION

Please mark the appropriate response (**failure to mark one of the three will result in denial of the application):**

_____ I am not subject to a court order for the support of a child.

_____ I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

_____ I am subject to a court order for the support of one or more children and am **not** in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

Applicant's Social Security number: _____

Applicant's Signature_____ Date_____ 20_____

Provide evidence of your good health and freedom from contagious disease; i.e., a physical examination performed by a licensed physician within 12 months preceding date of application (a Physician's Statement is provided).

VI. WORK HISTORY/PRACTICAL EXPERIENCE:

Please describe your CURRENT or most recent job and work back with your most recent employment at the top, describing EACH JOB HELD DURING THE PAST TEN (10) YEARS. If you were unemployed for longer than three (3) months, list the dates and your address in the experience block. You must complete the forms below. PLEASE DO NOT PUT "SEE RESUME".

Dates of Employment : From _____ To: Present
Mo. Day

Name of Employer/Business:_____ Address:_____

Phone Number: ( )_____ Type of Business: _____

Your Position/Title:_____ Number of Employees Supervised: _____

Briefly Describe Your Specific Duties:_____

Reason for Leaving: _____

Dates of Employment : From _____ To: _____
Mo Day Yr Mo Day Yr

Name of Employer/Business: _____ Address:_____

Phone Number: ( )_____ Type of Business: _____

Your Position/Title: _____ Number of Employees Supervised: _____

Briefly Describe Your Specific Duties:_____

Reason for Leaving: _____

Dates of Employment: From _____ To: _____
Mo Day Yr Mo Day Yr

Name of Employer/Business: _____ Address: _____

Phone Number: ( ) _____ Type of Business: _____

Your Position/Title: _____ Number of Employees Supervised: _____

BrieflyDescribeYourSpecificDuties_____

ReasonforLeaving:_____

_____

If needed, please use an additional sheet for work history information for 10-year period.

NOTE: LICENSURE IS MANDATORY IN THE STATE OF NEVADA!! YOU MAY NOT PRACTICE AS A RESIDENTIAL OR NURSING FACILITY ADMINISTRATOR UNTIL YOU HAVE FILED AN APPLICATION AND HAVE BEEN GRANTED A LICENSE IN THE STATE OF NEVADA.

You must sign this application. Read the following carefully before you sign . A false statement on any part of your application may be grounds for not licensing you, or for denial or revocation of your license. Also, you may be punished by fine or imprisonment (US Code, Title 18, Section 1001):

- **I understand that any information I give may be investigated as allowed by law or Presidential order.**
- **I consent to the release of information about my ability and fitness for licensure as a Residential/Nursing Facility Administrator by employers, schools, law enforcement agencies, other organizations, and other authorized individuals.**
- **I certify that I will uphold the rules and regulations relative to the responsibilities of an Administrator for Long-Term Care Facilities as required by the State of Nevada.**
- **I certify that, to the best of my knowledge and belief, all of my statements are true, correct, complete, and made in good faith.**

Applicant's Signature_____ Date _____

Revised 11/10/09

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DESCRIPTION:

Affix Passport-Size Photo Here

Color of Hair: _____
Color of Eyes: _____
Height:_____
Weight:_____
Date Photo was Taken: _____
(Note: Please affix passport-size photo on front page of application also)

IX. AFFIDAVIT

I declare that I am the applicant described and identified in this application for licensure in the State of Nevada.

I declare that I am qualified in all respects for the license for which I am applying in this application.

To the best of my knowledge, the information contained in this application and its supporting documents is free of fraud, misrepresentation or omission of material fact.

To the best of my knowledge, the information contained in this application and its supporting document(s) is truthful, correct and complete; and discloses all material facts regarding myself and associated individuals necessary to properly evaluate my qualifications for licensure.

I will ensure that any information subsequently submitted to the Board in conjunction with this application or its supporting documents meets the same standard as set forth above.

I understand it is unlawful and punishable by law to apply for or obtain a license or otherwise deal with the Board of Examiners for Long Term Care Administrators or a licensing board through the use of fraud, forgery or intentional deception, misrepresentation, misstatement or omission.

I authorize the Board of Examiners for Long Term Care Administrators to review and copy any documents pertaining to my past or present employment or character.

I release my past and present employers, references and all other persons whomsoever from any damage because of furnishing said information.

Attached is a copy of my driver's license or other photo identification.

Signed by: _____ Date: _____

Applicant's Signature _____

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X. ADMINISTRATOR FINGERPRINT PROCESSING INSTRUCTIONS

As an applicant for licensure with the Board of Examiners for Long-Term Care, it is your responsibility to obtain fingerprinting from an authorized law enforcement agency. Attached is an authorization form and TWO fingerprint cards which MUST BE COMPLETED.

It is imperative that the following blocks be COMPLETELY FILLED OUT.

APPLICANT FINGERPRINT CARD

Name: _____ **Height:_____**
(last, first, Middle)
Signature: _____ **Weight: _____**

Aliases (AKA): _____ **Color – Eyes: _____**

Citizenship: _____ **Color – Hair: _____**

Date of Birth: _____ **Place of Birth: _____**
Race: _____
Social Security Number: _____ **Sex: _____**

Signature of official taking fingerprints: _____

FINGERPRINT PROCESSING AUTHORIZATION FORM

I, _____, hereby consent to the
Last First Middle

examination of my fingerprints by the Federal Bureau of Investigation and a submission of their findings to the Board of Examiners for Long-Term Care. Applicants shall be given the opportunity to challenge the accuracy of information obtained through the Federal Bureau of Investigation as set forth in 16.34 of title 28 of CFR.

_____ _____
Signature Date

(Please note that Fingerprinting may be obtained at any local law enforcement agency.

IT IS IMPORTANT THAT FINGERPRINT CARDS NOT BE FOLDED WITHIN THE AREA WHERE PRINTS ARE TO BE TAKEN. ALSO, PLEASE REQUEST OF THE OFFICIAL TAKING YOUR PRINTS THAT THEY STAMP THE CARDS "BEST PRINTS OBTAINABLE".

Return this consent document and the fingerprint cards with your application to the Board office: B.E.L.T.C.A., 3157 North Rainbow Blvd., #313, Las Vegas, Nevada 89108

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PHYSICIAN'S STATEMENT

Date: _____ 19 _____

Applicant's Name: _____
Last First Middle Initial

Address: _____
Street City State Zip

I, _____, do hereby certify that I have examined the above named
Physician's Name
patient within the past year and he/she is free of communicable diseases, including Tuberculosis, and is in good mental and physical health, and is able to care for the elderly and/or infirm persons.

Physician's Signature _____

Physician's Name (Please Print or Type):_____

Address: _____
Street City State Zip

Telephone: ( ) _____

Please Note: This form must be completed by your physician and returned with your completed application..

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Fax No. (702 4865439
E-mail: beltca@govmail.state.nv.us

RELEASE OF INFORMATION

Having made application for licensure, I _____ hereby consent to have an investigation as to my moral character, professional reputation, education, experience and other qualifications for licensure as a Residential/Nursing Facility Administrator in the State of Nevada.

I authorize the State of Nevada and its State Board of Examiners for Long Term Care Administrators or their agents or representatives to acquire from any source of information it may request concerning my professional, academic and character qualifications. This information may include, without limitation implied by enumeration, confidential reports, file records, documents and transcripts of any type of civil, criminal, disciplinary, or administrative action or proceedings.

I authorize and request every person, physician, firm, corporation, government agency, or other institution having control of any documents, records, or other information pertaining to me, to furnish such information and to allow review and copying of such information to and by the authorized persons herein.

I acknowledge that I am aware of the laws and regulations regarding the licensure of Residential/Nursing Facility Administrators in the State of Nevada.

Applicant's Signature _____

Subscribed and sworn to before me this _____ day of _____, 19 _____.

Notary Public_____

Notary Seal **My Commission Expires _____**